Referral Cover Sheet

Thank you for choosing Cherishing Life Behavioral Home complete the attached Referral Form and send it along with the documents listed below. Having a complete referral packet will help us to begin services as soon as possible.

Please send the following <u>required</u> documents:

☐ . Completed Cherishing Life Behavioral Home Services Referral Face Sheet

☐ . T/RBHA Annual Behavior Assessment (reviewed and signed by BHP)

☐ . T/RBHA Treatment/Service Plan with RMBHS and specific services listed, i.e. Wellness, BHF, Counseling. (signed by BHP <u>and</u> guardian.)

☐ . Court Order for Guardianship (if the guardian is not the biological parent)

This Referral Cover Sheet can also serve as the fax cover sheet for your convenience.

To: Cherishing Life Behavioral Home
Services Intake Coordination

From: _____

Date Sent: _____

Number of Pages: _____

Phone: 480-590-5954
Fax: 480-590-5954
Email: info@cherishinglifehomes.com

This fax is confidential and intended solely for the use of the individual or entity to whom it is addressed. If you have received this fax in error please notify the sender and destroy this message.

Cherishing
LIFE BEHAVIORAL HOME

Referral Face Sheet

REFERRING AGENCY Referral Date: _____

Please √ the referring agency: ___Gila River ___Pascua Yaqui ___Salt River
(Intake Agency)

REFERRAL INFORMATION

Client Name: _____ Client Phone #: _____

Preferred Language: _____ Other Phone #: _____

Client Address: _____ City and Zip: _____

Address Directions: _____

_____

Social Security #: _____ AND AHCCCS ID#: _____

Client Date of Birth: _____ **CIS ID:** _____

Guardian(s) Name: _____Gender: _____Client Age: _____

Guardian Phone #: _____

DCS/TSS Legal Guardian?: ❑ **Yes** ❑ **No** If **Yes**, please provide primary care giver's name and Phone #:

_____

Emergency Contact(s): _____ Phone:_____

Reason for Referral: _____

Diagnosis Code(s): _____

Medications:_____

Allergies:_____

PCP Name: _____ PCP Phone #: _____

Services Requested:

❑ **Wellness Weekend/Community Based Support**(Respite, Psychosocial Rehabilitation, Case Mgmnt, Transportation, & Med Assistance)

Wellness Scheduling Frequency: ❑ Every 2-3 weeks ❑ Once A Month ❑ Only On CM Approval

❑ **Building Healthy Families/In-Home Support** (Counseling, Case Mgmnt, Family Support, Respite, Transportation, & Med Assistance)

❑ **Community Based Counseling** (Counseling, Case Management, Family Support, Transportation, & Medication Assistance)

REFERRING PROVIDER

Case Manager Name: _____ CM Phone #: _____

Signature: _____ CM Email:_____